Montana Healthcare Programs

Medication Assisted Treatment (MAT) Form

Patient Name:	Patient Medicaid ID#:	Patient DOB:
Provider Name:	Provider DEA# (**X-DEA required**):	
Provider Phone #:	Provider Fax #:	

Instructions:
This form is required for Montana Healthcare Program members who receive Medication Assisted Treatment (MAT). Answer the three questions and sign the form below:

Questions:

1. Has the Montana Prescription Drug Registry been reviewed: ◉ Yes ○ No
2. Has the member been educated on their outpatient prescription opioid, tramadol, and/or carisoprodol restrictions: ◉ Yes ○ No
3. Which medication is the member receving: ◉ Methadone ○ Buprenorphine Containing Product

Important Note:
Concurrent opioids, tramadol, or carisoprodol are not covered for members in Medication Assisted Treatment (MAT).

If a patient **subsequently discontinues medication assisted treatment (MAT), all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions**. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis ***only*** after the case is reviewed with the treating provider and the provider prescribing the buprenorphine-containing product.

Signature of Provider: _____Date: _____

Please complete this form and fax to Medicaid Pharmacy Program Staff at 1-406-444-1861